



Advanced Health
289 LaClair St, Coos Bay, OR 97420
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Fax: 541-269-7147 • TTY: 877-769-7400

Hospital Length of Stay Authorization Form

• For questions call: 541-269-7400 • Fax Completed Form and Records to 541-269-7147•
** PLEASE NOTE: INCOMPLETE FORMS WILL DELAY THE AUTHORIZATION PROCESS**

Member Name: _____ ID #: _____ DOB: ____/____/____

Date request submitted: ____/____/____

Name of Hospital/Facility: _____

Facility NPI#: _____

Date of Admission: ____/____/____

Admitting Diagnosis: _____

Mark one (required): [] Observation [] Initial length of stay [] Extended length of stay

Discharge Date: _____

Quantity of Days: _____

Plan of Care (Treatment/Meds., etc.)

Contact Person: _____ Phone: _____ Fax: _____

Disclaimer: Prior Authorization does not assure payment, which also depends on patient eligibility on date of service, contract terms, and compliance with rules, regulations and policies of DMAP, Medicare and Advanced Health as applicable.